



Roanoke
 1505 Franklin Rd. SW
 Roanoke, VA 24016
 T (540) 343 -7331
 F (540) 343 -7349

Lynchburg
 2015 Tate Springs Rd.
 Lynchburg, VA 24501
 T (434) 846-2244
 F (434) 846-0602

Salem
 3529 Keagy Rd.
 Salem, VA 24153
 T (540) 343-7331
 F (540) 725-1356

Patient Information Sheet

Patient's Name (Please print and include middle initial)		Sex M F	Marital Status S M W D Sep	Age	Home Phone
Date of Birth	Social Security #	Race/Ethnicity			Cell Phone
Street Address	Apt. Number	City	State	Zip Code	Email Address
Preferred Method of Contact: <input type="checkbox"/> <input type="checkbox"/>					
Primary Care Physician		Address			Phone
Referring Physician		Address			Phone
Emergency Contact		Address			Phone
How did you find out about our office?					
If Patient is an Adult					
Patient's Employer and Address					Work Phone
Spouse's Name		Spouse's Date of Birth	Spouse's Social Security #	Spouse's Cell Phone	
Spouse's Employer and Address					Spouse's Work Phone
If Patient is a Child					
Father's Name		Father's Date of Birth	Father's Social Security #	Father's Cell Phone	
Father's Address (If different)		Father's Employer and Address			Father's Work Phone
Mother's Name		Mother's Date of Birth	Mother's Social Security #	Mother's Cell Phone	
Mother's Address (If different)		Mother's Employer and Address			Mother's Work Phone
Parent's Address (if different from patient's)					Home Phone
Insurance Information *We will only bill Primary and Secondary					
Name of Primary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #	
Name of Secondary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #	

Signature: _____

Date: _____



NEW PATIENT EVALUATION
SECTION I: CLINICAL HISTORY

1. **Name:** _____ **Date:** _____

2. **Chief Complaint:** Describe in the patient's own words, the problems that bring them here for evaluation.

<p>a) Have your health problems caused you to miss any work or school days over the past year? Yes / No If yes, how many? _____</p> <p>b) Have your family members missed any days of work or school because of your health problems? Yes / No If yes, how many? _____</p> <p>c) Have you required emergency treatments or hospitalization for this? Yes / No How many times in the past year? _____</p> <p>d) When did your main symptoms first appear? _____</p>	<p>e) When did the latest attack start and end? _____</p> <p>f) How often do you have these problems? _____</p> <p>g) How long do they last? _____</p> <p>h) Which of these symptoms do you have every day? _____</p>
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<p>3. History of Present Illness: Oculo-Nasal</p> <p>a) Do you have any eye or nasal symptoms? Yes/No If no, please skip item #4 below</p> <p>b) How long have you had these? _____</p>	<p>5. History of Present Illness: Pulmonary</p> <p>a) Do you have any chest symptoms? Yes/No If no, please skip item #6 below</p> <p>b) How long have you had these? _____</p>
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4. Check those eye or nasal symptoms that apply:	6. Check those "chest-related" symptoms that apply:
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Yes	None	Circle those symptoms that are most severe	Yes	None	Circle those symptoms that are most severe
		a) Runny nose / clear, watery			a) Chest tightness
		b) Blockage (plugged up)			b) Chest congestion
		Trouble with nose breathing			c) Frequent cough
		c) Sneezing spells or fits			Nocturnal cough
		d) Trouble smelling things			Cough with exertion
		e) Post-nasal drainage			Cough with laughing/screaming
		Thick, discolored drainage			Cough at rest
		Thin, clear, watery drainage			Coughing up discolored mucus
		f) Itching of eyes			Coughing up blood
		Of ears			d) Difficulty walking up stairs
		Of nose			Difficulty breathing
		Of throat			Trouble taking a deep breath
		Of roof of mouth			Shortness of breath
		g) Dryness or nose bleeds			Difficulty running
		h) Frequent colds or infections			Difficulty walking around
		Earaches or ear infections			Easy fatigability
		Sinus infections			e) Ever diagnosed as asthma
		i) Throat tickle with cough			f) Do you ever wheeze?
		j) Throat or face swelling			Hospitalized for wheezing
		k) Eyes - burning			Wheezing attacks
		Watery			Wheezing with colds
		Puffy or swollen eyes			Wheezing with exercise
		l) Frequent headaches			Wheezing at night
		Sinus headaches			Wheezing at rest
		Migraine headaches			g) Snoring
		Tension headaches			h) Mouth breathing

Patient Name:

Date:

<p>7. Do you have any skin problems? Yes / No</p> <p>If no, please mark "None" in the boxes to the right</p> <p>a) How long have you had these? _____</p> <p>If you have hives, welts, swelling, or urticaria, please complete the "Hives Questionnaire"</p> <p>b) Please describe your skin problem:</p>	Check level of severity →	None	Mild	Mod	Severe
	a) Generalized itching				
	b) Swelling				
	c) Eczema / Atopic dermatitis				
	d) Skin infections				
	e) Rash with metal				
	f) Poison ivy / oak / sumac				
	g) Psoriasis				
	h) Seborrhea				

8. Do your symptoms vary with the seasons: Yes / No If no, tell us if you have them all year or go to section #9

Mark the time of year when you have the following symptoms	All year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Nasal Symptoms													
Eye symptoms													
Chest symptoms													
Skin problems													
Other: (specify)													

<p>9. Please list any medications you may have taken recently or take on a regular basis and the dose. (include OTC & BCPs) (If you need more space, list them in the unused blocks under item #10)</p>			<p>10. Do you have any medication allergy or adverse reactions? Yes / No If no, please skip this section.</p>		
Medication:	Dose taken	Last dose	Medication:	Reaction	When

11. Have you ever been evaluated for allergies in the past? Yes / No

a) If yes, to what tests were you found to be allergic?

b) Did you receive allergy injections? Yes / No How long? _____ Did they help? Yes / No When were they stopped? _____

12. Family History: Circle those medical conditions which may run in your family. List family member(s) in the box.

Aspirin reactions		Hay fever	
Bronchial asthma		Hiatal hernia	
Blocked nose		Hives	
Diabetes		Migraine headaches	
Eczema		Sinusitis	
Emphysema		Tuberculosis	
Food allergy		Other (specify)	

Patient Name: _____

Date: _____

15. If female, are you pregnant or trying to achieve pregnancy? Yes / No Date of LMP: _____

16. Ancillary Allergy History:

a) Do you have any problems with any foods? Yes / No

Describe: _____

b) Do you have any problems with insect stings? Yes / No

What kind? _____

Have you ever had any reactions that were more than large local swelling? Yes / No

17. Neonatal History: (Circle appropriate answer)

a) Were you breast-fed, bottle-fed, or both?

b) Did you have problems with baby formulas? Yes / No

If so, which ones? _____

c) Were you premature? Yes / No

d) Did you have newborn breathing problems? Yes / No

18. Immunizations:

a) Initial childhood immunization series Yes / No

b) Tetanus booster in 10 years Yes / No

c) Chicken pox vaccine Yes / No

d) MMR booster Yes / No

e) Typhoid Yes / No

f) Pneumococcal vaccine Yes / No

g) Prevnar Yes / No

h) Hepatitis B series Yes / No

i) Influenza: (date of last dose) _____

19. Check those medical conditions which you have had in the past.

Review of Systems:

Past Medical History:

Do you suffer from any of the following:	Frequency	Date of last episode	Have you had any of the following conditions:	When?
Sinusitis			Nasal polyps	
Bronchitis			Emphysema	
Pneumonia			Tuberculosis	
Asthma attacks			Diabetes	
Bladder problems			Kidney disease	
Muscle or back trouble			Liver disease or hepatitis A, B, or C	
Arm or shoulder trouble			Carpal tunnel syndrome	
Arthritis			Cancer	
Tendonitis or joint trouble			Chicken pox	
Irregular heartbeat			Heart disease/rheumatic fever/murmur	
High blood pressure			Thyroid: high low (circle)	
Alcohol use			Addiction	
Substance abuse			Sinus surgery	
Depression/nervous disorders			Sinus x-rays: yes/no Normal: yes/no	
Dizziness or vertigo			Sinus CT scan: yes/no Normal: yes/no	
Bleeding problems or easy bruising			Last chest x-ray	
Hiatal hernia/GERD			Hysterectomy	
Frequent heartburn or stomach ulcers			Nasal polypectomy	
Bedwetting			PE ear tubes, tonsil or adenoidectomy	
Seizures/convulsions			Other Surgeries:	
Hair loss				

19. Additional Comments:

Signature: _____

Date: _____



Notice of Privacy Practices

Effective Date: 03/25/2003 Last Revised: 03/23/2026

Allergy & Immunology of Virginia, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Main Office
1505 Franklin Road SW
Roanoke, VA 24016
Ph: 540-343-7331
Fax: 540-343-7349

Salem Office
3529 Keagy Road
Salem, VA 24153
Ph: 540-981-5653
Fax: 540-725-1356

Lynchburg Office
2015 Tate Springs Road Suite A2
Lynchburg, VA 24501
Ph: 434-846-2244
Fax: 434-846-0602

Dear Patient,

During your relationship with Allergy and Immunology of Virginia, LLC (DBA Asthma & Allergy Center), we will create and obtain information about your health care. This information will be kept in your chart (your medical record) and will include office visit notes, results of lab tests and x-rays, records obtained from other health care providers, insurance payment information, and other documents. Your medical record is the physical property of Allergy and Immunology of Virginia, LLC (DBA Asthma & Allergy Center), but the information contained in it belongs to you. This information is confidential, and we will protect it from inappropriate use or disclosure. If you have questions regarding our practices, this notice, or your visit, please don't hesitate to contact me.

Cari Humphries, Practice Administrator & Privacy Officer
1505 Franklin Rd SW Roanoke, VA 24016 • Phone (540) 343-7331 • Fax (540) 343-7349

1. Our practice is allowed by law to use and disclose your protected health information without your written authorization for the purpose of treatment, payment, and health care operations.

We will give you a Consent Form to sign, which documents that you understand that your health information may be used and disclosed without your written authorization under the following circumstances:

- **For your treatment.** For example, Information about you may be released to your family doctor to coordinate your care. A diagnosis of your medical condition may be disclosed to a home health provider on an order for equipment. Or a symptom you are experiencing may be released to a hospital radiology department to document your need for an X-ray.
- **For payment.** For example, your diagnosis and treatment information may be submitted on a claim to your insurance carrier to obtain payment for your office visit. Or a copy of your office notes may be sent to your insurance carrier to document medical necessity.
- **For health care operations.** For example, your insurance carrier may review information from Your record to perform a quality assessment of our services.

2. We may share some limited information with people involved in your care, such as family members or other people as designated by you.

- Examples of this shared information are appointment dates and times, the date of your next scheduled injection, and allowing a family member or friend to pick up samples of medications for you.
- We may leave limited information on your home answering machine or with an individual who answers your home phone if you are not at home when we call.
- If you wish to approve a friend to receive the limited information described above, or if you do not wish us to share limited information as described above with a family member, please notify us.

3. Your health information may also be used or disclosed without your written consent or authorization under other circumstances, provided certain conditions are met. Some examples are as follows:

- In response to the reasonable belief that an individual may be a victim of abuse, neglect, or domestic violence (such as to a social services agency or a protective services agency)
- In response to judicial and administrative proceedings (such as in response to a valid subpoena)
- For law enforcement purposes (such as providing limited information to identify and locate a fugitive or material witness)
- For public health activities (such as to an authority collecting information to control disease), for health oversight activities (such as in audits, or in civil or criminal investigations)
- About decedents (such as to a coroner or funeral director)
- For research purposes (no information will be linked to your personal identity)
- To avert a serious threat to health or safety (such as to law enforcement officials to identify or apprehend an individual)
- For specialized government functions (such as to federal officials for the conduct of lawful intelligence or to a correctional institution about an inmate)
- For workers' compensation

4. Uses and disclosures other than those listed above in Sections 1 and 2 require your written authorization. Your authorization is a detailed document that gives us permission to:

- Use your health information for a purpose you have specified (which is other than treatment, payment, or health care operations), or to
- Disclose your information to a third party specified by you.
- You may revoke your authorization; you must request this in writing

5. Your authorization is required for the sale of your information, or for the use or disclosure of your information for marketing purposes.

6. Your authorization is required for use or disclosure of any of your psychotherapy notes.

7. Our practice may contact you to:

- Remind you of appointments (sometimes in the form of a postcard reminder for allergy shots),
- Give you information about treatment alternatives which may be of interest to you, or
- Offer you the opportunity to be considered for participation in a clinical research study.

8. You have the right to:

- Restrict disclosures to your health plan for the purpose of payment or health care operations
When the information pertains solely to an item or service for which you have paid us in full. Please notify us of your wishes by completing a Restriction Form before you leave.
- Request restrictions on certain other uses and disclosures.
- Receive confidential communications of your health information (please specify the method in writing)
- Inspect and copy your health information, including an electronic copy if requested
- Amend your health information (A practice has the right to deny the amendment under certain circumstances)
- Receive an account of our disclosures of your information
- Receive a paper copy of this Notice

9. Our practice has the following responsibilities:

- We will maintain the privacy of your protected health information and will provide you with notice of our legal duties and privacy practices regarding your health information
- We will abide by the terms of the notice currently in effect at the time of disclosure

- If we change our privacy practices as described in our Notice, we will provide you with a revision Notice.

If you feel your privacy rights have been violated, you may complain to our Privacy Officer, Cari Humphries (540) 343-7331, or write to her care of: Allergy and Immunology of Virginia, LLC (DBA Asthma & Allergy Center) 1505 Franklin Road, SW Roanoke, VA 24016

- You may also file a complaint with the Secretary of Health and Human Services
- There will be no retaliation against you if you file a complaint.

You may obtain a summary copy of the privacy regulation from our office on request, or from the Department of Health and Human Services.

Allergy and Immunology of Virginia, LLC (DBA Asthma & Allergy Center) reserves the right to change the terms of our Notice and to make the new notice provisions effective for all protected health information we maintain. If we change our privacy practices, we will provide you with a copy of our revised Notice at your next office visit.

If you have questions or would like further information, you may speak to our Privacy Officer, Cari Humphries (540) 343-7331

Acknowledgements

Printed Name of Patient: _____ **Date of Birth:** _____

If the patient is a minor or legally unable to sign, please list the name of the person completing this form below.

Printed Name: _____ **Relationship:** _____

Notice of Privacy Practices

Your signature on this form acknowledges that you have received our Notice of Privacy Practices.

Date: _____ **Signature:** _____

(A photocopy of this authorization shall be considered valid as the original.)

Consent to Treat – Assignment of Benefits – Financial Agreement

I give Allergy & Immunology of Virginia, LLC permission to provide such medical care as may, in their opinion, be medically necessary. I have the right to discuss my care and treatment with my provider, and to refuse care or treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of any procedure, treatment, or examination. **INSURANCE:** It is the patient's responsibility to provide our office with current insurance information and to complete any forms necessary to expedite payment by the insurance provider. I am responsible for obtaining any referrals required by my insurance. I further give ongoing authorization for payment of insurance benefits to be made directly to this practice for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. By signing this form, you acknowledge that you understand and authorize Allergy & Immunology of Virginia, LLC, to send emailed receipts of payment when requested by you. These receipts will be transmitted over an insecure channel, and there is a chance they may be intercepted by a 3rd party. In the event of default, I agree to pay all collection fees, court costs, and/or attorney fees incurred or imposed by Allergy & Immunology of Virginia LLC. (DBA Asthma & Allergy Center)

Date: _____ **Signature:** _____

(A photocopy of this authorization shall be considered valid as the original)

Notice of Deemed Consent

Virginia law 32.1-45.1 requires health care providers to notify you that the Hepatitis B and C and/or HIV (AIDS) Virus testing may be done on a sample of your blood if a health care worker is exposed to your blood or body fluids in a manner that might transmit these diseases. The following notice is to advise you that this policy is in effect at our clinic. Any testing will be performed at no cost to you. If such an exposure occurs, you will be given information about the reason for your testing and will have the opportunity to ask questions about the process. If your blood test is positive for the disease(s) listed above, the attending physician will notify you and any person exposed, as well as the Virginia Department of Health. Your signature below indicates that you have been informed of this law and that you authorize the release of any information required to perform the testing outlined above.

Date: _____ **Signature:** _____

(A photocopy of this authorization shall be considered valid as the original)

Proxy

Proxy forms will be required for:

- Any minors who will be accompanied to follow-up appointments or allergy shots with anyone other than a parent / legal guardian
- Any minors need permission to bring themselves to follow-up appointments or allergy shots.

A parent/ legal guardian must be present for the Initial Appointment or Appointments with Testing unless prior arrangements have been made.

Printed Name of Patient: _____ **Date of Birth:** _____

Late Cancellation and No-Show Policy / Late Arrival Policy

There will be a **\$60 charge** for a Late Cancellation OR No-Show Appointment for current established patients. This IS NOT billable to your insurance and is due PRIOR to scheduling another appointment.

Definitions:

Late Cancellation: Any scheduled appointment not canceled or rescheduled at least 24 hours in advance. New Allergy Testing patients must notify us EIGHT days prior to their appointment.

No-Show: Any scheduled appointment that is missed without prior notice.

Established Patients who miss THREE scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

New Patients who miss TWO consecutive initial office visits without providing at least 24 hours' notice may not be permitted to schedule another appointment.

New Patients scheduled for Allergy Testing appointments must notify us **EIGHT days prior** to the appointment if they need to cancel or reschedule. Failure to notify us EIGHT days prior will result in a **\$75 charge** for a late cancellation or no-show, and you will not be permitted to schedule any further appointments with our practice.

Late Arrival Policy: If you are more than fifteen minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day, but this is not always an option.

Date: _____ **Signature:** _____

(A photocopy of this authorization shall be considered valid as the original)



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Authorization for Use or Disclosure of Information

Patient Name: _____ Date of Birth: _____

Guardian/ Representative (if applicable) _____

Relationship to Patient: _____

I, the undersigned, hereby authorize The Asthma & Allergy Center to disclose the following protected health information (PHI): Please check the applicable box(es)

Limited information: _____
 (Please list the limited information you wish to disclose.)

My complete medical record, including lab work and test results.

To the following entities: _____
 (Please list the medical practice name or the name of the physician who will receive your records.)

Phone: _____ Fax: _____
 (Please provide the medical practice phone and fax numbers to which your records will be sent.)

For the following use or purpose(s):

This authorization shall expire on this date: _____

I understand that I have the right to revoke this authorization in writing at any time by sending written notice to Cari Humphries at the Roanoke address listed above. I understand that revocation is not effective to the extent that The Asthma & Allergy Center has relied on the use or disclosure of the PHI. I further understand that, in accordance with state and federal law, there may be a charge associated with copying my records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Asthma & Allergy Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

- I understand that I have the right to:
- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
 - Refuse to sign this authorization.

Date: _____ **Signature:** _____